DEPARTMENT OF SOCIAL & HEALTH SERVICES
Health & Recovery Services Administration
July 22, 2005

SeaTac Marriott
3201 S. 176th Street
Seattle, WA 98188

Members Attending

Barbara Malich
Maria Nardella
Chris Jankowski, OD
Annette English for Claudia St. Clair
Eleanor Owen
Blanche Jones
Jerry Yorioka, MD
David Gallaher
Kathy Carson
Mark Secord
Elyse Chayet

Members Not Attending

Janet Varon
Allena Barnes
Steven Gobin
Paulette Roe

HRSA Staff

Doug Porter
Debbie Meyer
Jim Stevenson
Steven Wish
MaryAnne Lindeblad
Jeff Thompson
Roger Gantz

Guests

Bob Perna
Robin Arnold-Williams

Approval of the Minutes

The minutes for the March 25, 2005, meeting were approved. The agenda was approved as well.

GMAP

Governor/Secretary's health care GMAP will include three pieces:
1) cost containment initiative
2) cover more children
3) health promotion

The workgroup is well on its way to getting measures defined.

More affordable health care coverage – those folks that don't have private coverage might get services through Medicaid or SCHIP

A wellness piece – includes immunization, tobacco cessation, and injury prevention.

Tough one is cost containment. The Governor wants to bring growth in health care spending in line with growth of state revenue.

The group's workplan includes a health summit sometime in October (possibly October 25) to bring together all interested public and private parties to talk about health care.

We are hopeful this is going to be a positive opportunity.

Children's Health Program

The Governor pushed reinstatement of the undocumented and immigrant population – primarily children – who lost Medicaid enrollment three years ago. We are currently planning how we will go about reauthorizing this program, which is for children under 18 who aren't eligible for Medicaid because of citizen status. It will be implemented in January 2006, and we believe there are approximately 4,300 children who can be enrolled with current funding. Second year funding should allow us to enroll another 3,800 children.

Eligibility will be done centrally in our MEDS program since we need to monitor the number enrolled. We also are looking at maximizing state dollars because we can get federal match for emergency services.

We want to make the best program that we can with the limited resources. For the first year of the program, it will be a fee-for-service program. We need to have a year's worth of data to see the use of this group to see what the expenditure patterns are, so that we could consider using managed care coverage in future years. A workgroup will continue to look at the data to evaluate

Budget is $2 million for the biennium.

Technology update on MMIS

We are moving into a design stage for the new Medicaid Management Information System (MMIS). CNSI is the contractor – the same company that is implementing a new MMIS in Maine that is riddled with problems. We have been in contact with various staff in Maine to learn from these mistakes.

CNSI isn't new to technology, but the company is relatively new at establishing an MMIS system. That means we will keep the vendor on a tight leash, making sure that CNSI stays current on its deliverables. We do have assurances from CMS that if the vendor can't meet its deadlines, then we can take the project back out for rebidding.

June 2007 is the approximate date for bringing up the new MMIS system.

The major problem in Maine was that CNSI didn't do a good job of working with providers. The system encountered a 70% denial rate of claims when it was launched.

The MMIS is also part of GMAP, under program efficiencies.

Because of that, we will be giving the Governor and her Information Services Board regular updates on how the reprocurement is going.

Delay in Enteral Nutrition Changes

Dr. Thompson assured the advisory committee that if clients need nutrition they will get it. The reason we are tightening the requirements is that there have been no parameters around getting enteral nutrition in the past.

However, HRSA has ordered another delay in the program, this time to October 1, 2005. We convened a stakeholder work group to look at simplifying the form that needs to be submitted. We are using a very good prior authorization criteria. If you can show medical necessity by using the criteria, the client will receive the enteral nutrition.

Dr. Thompson said that some questions have arisen around children who have autism. The other area of difficulty is for those senior citizens that have Alzheimer's and are not getting appropriate nutrition from a regular diet.

What we are trying to eliminate are those providers who were ordering nutrition on a regular basis for their clients without establishing a medical need. Those clients too often were just getting a shipment on a regular basis without a real need – a bonus for the drop-and-ship supplier, but providing no benefit to the client.

Medical Necessity & Prior Authorization

Dr. Thompson also outlined the recent moves toward evidence-based decision-making in Medicaid. He said the program is about ready to launch an A-B-C-D model.

A – Good evidence, we'll pay for it
B – Consistency in literature, but we're going to keep an eye.
C – When the literature doesn't show good results, we're asking for more information or denying the procedure
D - When there is no literature showing that the service is ineffective or unsafe, we have a responsibility to protect our clients.

This is directly related to GMAP. When the Governor introduced Steve Hill, she noted a study that stated 30% of health-care services being provided to patients weren't actually needed. We're looking at a balance of reasonable services for people.

RSN Contracts

MaryAnne Lindeblad talked about what's happening in the world of Regional Service Networks (RSNs) and community mental health services.

Under new state law, the RSNs are going to be required to bid for the business in the future, and the Mental Health Division in HRSA is in the process of developing an RFQ that will go to the RSNs during August or September. This RFQ is the framework required under the new legislation. Bid winners will be announced in January 2006.

In part, this is a move to increase access to evidence-based decision-making, looking at different ways of serving the clients. The procurement team includes Mental Health, Contracts, other HRSA divisions and Mercer, a consulting group out of San Francisco. This team has been put together to write the RFQ & the RFP. We are meeting with providers, consumers and tribes on developing these documents.

Because it's an RFQ, it's not a public process, but MaryAnne said the team is trying to get as much input from people as we can. This is a very new process and the RSNs are understandably nervous about it. Depending on the size of the RSN, it could be a very different playing field – and some RSNs have never had to go through an RFQ process in the past.

What is the overlay with the Medicaid Waiver? That's difficult to say. The system is still in play with the waiver. But because of changes in the funding we have to keep the Medicaid dollars and the state dollars separately.

HRSA Reorganization

Doug Porter noted that we are still looking for a title that rolls off the tongue, but for the moment, DSHS has settled on Health and Recovery Services Administration (HRSA).

That was only one of the consequences of the Secretary's decision to realign the Mental Health Division and the Division of Alcohol and Substance Abuse with Medical Assistance Administration. In addition, Mercer had been asked to return to DSHS and do an assessment of the Mental Health Division and how it would fit into the new world created by HB 1290. In July, Doug and the Secretary asked Mercer to take a look at its conclusions in view of the new realignment. We are still awaiting those recommendations.

Doug said we are looking at streamlining some of the administrative functions as the divisions are melded into the new administration. The expectation is to get the bureaucracy aligned. But Doug said those decisions are premature prior to getting Mercer's second report, anticipated sometime in September. Doug stated he didn't have a new org. chart to show the committee members. He said the realignment would include changes in the structure of the former medical assistance divisions. Those changes were discussed by the former MAA directors, Doug and Heidi at a retreat early in the summer before the larger realignment occurred.

Comments from the DSHS Secretary – Robin Arnold-Williams

The department is functioning pretty well overall, Robin said. We have great staff and they are doing good work. She described her own background in Utah state government, noting that she spent most of her time there in the Human Services arena. Having Medicaid as part of her agency is a new challenge, although she has had prior experience with Mental Health and Alcohol and Substance Abuse. In Utah, she also merged Mental Health and Alcohol and Substance Abuse into one operation, but at this time she has no plan to merge them here in Washington.

The weaknesses of Mental Health brought up in the Mercer Report showed that there were deficits in staffing. Robin decided rather than duplicate the expertise needed, she would share MAA's expertise with the Mental Health Division.

Robin said she also is encouraging Doug to look at the various advisory committees to see if they are all needed or if there might be a way to combine committee roles that makes sense.

The Governor has charged DSHS with cost containment goals, but she has ruled out eligibility changes. This isn't an easy task, but she is passionate about getting medical coverage for all children by 2010. The clear message is to contain costs without jeopardizing Medicaid services, especially for children.

Robin believes that we will need the waiver process to bring Medicaid reform to our state, but we'll need the help of a lot of people to help us determine what to submit in a waiver. Roger and Doug have been meeting with the Governor's staff in preparing for the GMAP process. Some key issues:

Eligibility. – the Governor doesn't want us to cut eligibility
Rates – the rates are as low as they can go without providers declining to see our clients.
Benefits - we will be looking at cost-sharing. We need to look at $5 to $10 copays so that clients also become responsible for their care. Hospitals need to triage clients and find those that are using the hospitals for the primary care vs. the need for emergency services.

2005-07 Budget

Time was short at the end of the meeting, so Roger handed out a 2005-007 Budget Policy Implementation Matrix and quickly walked committee members through it. He stated that he would be happy to answer any specific questions that the members might have.